UT★Physicians

NEW PATIENT HEALTH HISTORY BEHAVIORAL HEALTH

Patient Name:_____ Date: _____

Age: _____ Date of Birth: _____ Phone #: _____

☐ Male ☐ Female Marital Status (Adult): _____ Occupation (Adult): _____

Pharmacy Name: _____ Pharmacy #: _____

PAST ILLNESS/CONDITIONS/PROBLEMS

Please check if you or someone in your family have had these illnesses, conditions, or problems

	You	Your Family
Anemia/Blood Problems/Bleeding	☐	☐
Anxiety	☐	☐
Arthritis/Rheumatism or Gout	☐	☐
Bipolar Disorder	☐	☐
Bladder/Kidney Problems	☐	☐
Eye Disease	☐	☐
Asthma/Allergies	☐	☐
Tuberculosis	☐	☐
Duodenal/Stomach Ulcer	☐	☐
Diabetes	☐	☐
Tumor/Cancer	☐	☐
High Blood Pressure/Stroke	☐	☐
Heart Problems	☐	☐
Convulsions/Epilepsy	☐	☐
ADHD	☐	☐
Eating Disorder	☐	☐
Mood Disorder	☐	☐
Autism	☐	☐
Tourette's	☐	☐
Auditory or Visual Hallucinations	☐	☐
Depression	☐	☐
Schizophrenia	☐	☐
Suicide/Suicide Attempts/Suicide Ideations	☐	☐
Alcohol/Drugs	☐	☐
Problems with Law/Imprisonment	☐	☐
Other: _____	☐	☐

Alcohol Use:

How many times in the past year have you consumed 4 drinks or more in one sitting? _____

Is your alcohol use a concern for you or others?

☐ Yes ☐ No

REASON FOR PAST HOSPITALIZATIONS

_____

_____

_____

_____

_____

_____

_____

Year: _____

Year: _____

Year: _____

Year: _____

ALLERGIES (FOOD & MEDICATION)

_____

_____

CURRENT MEDICATIONS

Current Medications: Please include prescribed, over the counter, birth control pills, supplements, vitamins, and herbs.

Name	Dosage (how much)	How often	How is it taken
1.			☐ Mouth ☐ Cream ☐ Other
2.			☐ Mouth ☐ Cream ☐ Other
3.			☐ Mouth ☐ Cream ☐ Other
4.			☐ Mouth ☐ Cream ☐ Other
5.			☐ Mouth ☐ Cream ☐ Other
6.			☐ Mouth ☐ Cream ☐ Other

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REVIEW OF SYMPTOMS Please check any **current / recent** symptoms you have:

General:
___ Fatigue
___ Always hungry
___ Lived outside USA
___ Other _____

Skin:
___ Pimples or rashes
___ Changes in moles
___ Lumps under skin
___ Bruise easily
___ Night sweats

Eyes:
___ Wear eyeglasses
___ Blurry vision
___ Double vision
___ See halos

Ears:
___ Ears discharge
___ Ringing inside ears
___ Hearing problems
___ Earaches

Mouth:
___ Sore tongue
___ Sore/Swollen gums
___ Trouble with teeth
___ Changes in taste

Nose/Throat:
___ Nasal congestion
___ Runny nose
___ Sore/Hoarse throat
___ Frequent head-colds
___ Nose bleeds

Digestive:
___ Problems swallowing
___ Nausea/vomiting
___ Stomach pain
___ Vomiting blood
___ Constipation
___ Diarrhea
___ Black/bloody stools
___ Rectal bleeding
___ Bowel changes

Respiratory:
___ Often short of breath
___ Wheezes
___ Cough up mucus
___ Cough up blood

Cardiovascular:
___ Tire quickly
___ Ankles/feet swell
___ Dizziness
___ High blood pressure
___ Racing heart
___ Irregular heart beats
___ Pain/chest tightness
___ Heart murmur

Urinary:
___ Hard to urinate
___ Urgency
___ Pain in urination
___ Frequency while awake
___ Frequency while asleep
___ Lose bladder control
___ Brown/bloody urine

Male Genital:
___ Unusual discharges
___ Weak urine flow
___ Erection difficulties
___ Painful intercourse
___ Swelling of testicles
___ Pain in testicles

Female Genital:
___ Last period _____
___ Last PAP smear _____
___ Vaginal discharges
___ Premenstrual tension
___ Bleed between periods
___ Menstrual problems
___ On birth control pills
___ Lumps in breast
___ # of pregnancies _____
___ # of live births _____
___ Miscarriages
___ Abortions
___ Stillbirths
___ Premature births
___ Cesareans

Musculoskeletal:
___ Swelling of joints
___ Swelling of armpits
___ Swelling of groin
___ Joint pain/stiffness
___ Hot/red joints

Head/Neck:
___ Lumps in neck
___ Frequent headaches
___ Noises in head

Neurological:
___ Tremors/shakes
___ Blackouts
___ Convulsions
___ Head injuries

Psychiatric:
___ Problems with family
___ Problems at work
___ Shy/sensitive
___ Cannot relax/tense
___ Worry a lot
___ Cannot concentrate
___ Memory problems
___ Hopeless outlook
___ Angry/irritated
___ Guilt free
___ Cry a lot
___ Loss of appetite
___ Weight changes
___ Trouble sleeping
___ Loss of sexual desire
___ Suicide attempts
___ Depressed
___ Sexual problems
___ Bad dreams/nightmares
___ Bad thoughts
___ Hear voices
___ Smoke tobacco
___ Daily alcohol
___ Smoke marijuana
___ Use cocaine
___ Use heroine
___ Use other drugs
___ Loss of control
Other _____
_____
_____
_____
_____